



WYOMING GAME AND FISH DEPARTMENT

HUNTING SEASON EXTENSION PERMIT APPLICATION



APPLICANT COMPLETE:

Last Name		First Name	Middle Initial	Date of Birth (MM/DD/YYYY)	XXX-XX- Social Security Number (Last Four (4) Digits REQUIRED)
Mailing Address		City	State	Zip Code	Daytime Phone Number
Physical Address		City	State	Zip Code	Email Address (optional)
Weight (lbs)	Height (Ft' Inches")	Eye Color	Hair Color	Sex	

I do hereby swear that I have a central visual acuity disability, am quadriplegic, upper extremity disabled, paraplegic, permanently paralyzed over at least fifty (50%) percent of my body *or* otherwise physically disabled so as to be permanently confined to a wheelchair (or similar device) (as defined by Commission Regulation, Chapter 35).

Applicant's Signature and Date

or

Parent/Legal Guardian's Signature and Date

Wyoming Game and Fish Commission Regulation, Chapter 35, Section 10. Hunting Season Extension Permits:

(a) Any person may be issued a Hunting Season Extension Permit which allows a qualified applicant to hunt antelope, deer or elk five (5) days prior to the earliest opening date in the hunt area(s) and for the sex of antelope, deer or elk set forth by limitations of their license as specified in Section 2 of the current regulation for that species (Commission Regulations Chapter 5, Antelope Hunting Seasons, Chapter 6, Deer Hunting Seasons; Chapter 7, Elk Hunting Seasons), provided the person requesting the hunting season extension permit:

(i) **Has a Central Visual Acuity Disability, is quadriplegic, upper extremity disabled, paraplegic, permanently paralyzed over at least fifty (50%) percent of their body or otherwise physically disabled so as to be permanently confined to a wheelchair (or similar device)** (as defined by Commission Regulation, Chapter 35).

PHYSICIAN MUST COMPLETE:

I, the undersigned, swear that I am a licensed medical doctor, nurse practitioner, physician's assistant, optometrist or ophthalmologist and find the above named applicant to have a central visual acuity disability, is quadriplegic, upper extremity disabled, paraplegic, permanently paralyzed over at least fifty (50%) percent of their body *or* otherwise physically disabled so as to be permanently confined to a wheelchair (or similar device) (as defined by Commission Regulation, Chapter 35).

Name of licensed medical doctor, nurse practitioner, physician's assistant, optometrist or ophthalmologist (PLEASE PRINT)

Phone Number

Address

City

State

Zip Code

Signature of licensed medical doctor, nurse practitioner, physician's assistant, optometrist or ophthalmologist

Date

THIS APPLICATION CANNOT BE ALTERED. ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

Wyoming Game and Fish Commission Regulation, Chapter 35, Section 13. **Making False Statements to Obtain a Permit.** Any person who makes a false statement on an application to obtain a permit or any medical doctor, nurse practitioner, physician assistant, optometrist, or ophthalmologist who makes a false statement on an application in order that a person might fraudulently obtain a permit shall be in violation of this regulation and such violation shall be punishable as provided by Title 23, Wyoming Statutes.

Permits are issued only at Wyoming Game and Fish Department Regional Offices located in JACKSON, PINEDALE, CODY, SHERIDAN, GREEN RIVER, LARAMIE, LANDER, CASPER or the Wyoming Game and Fish Headquarters located in CHEYENNE.

MAIL TO: WYOMING GAME AND FISH DEPARTMENT
LICENSE SECTION
5400 BISHOP BLVD
CHEYENNE, WY 82006-0001

OFFICE USE ONLY

Permit#:

Issued By:

Date Issued:

FAXED OR EMAILED COPIES WILL NOT BE ACCEPTED